Medical Errors and Patient Safety

Commission to Study Maine's Hospitals

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NATIONAL ACADEMY

for STATE HEALTH POLICY

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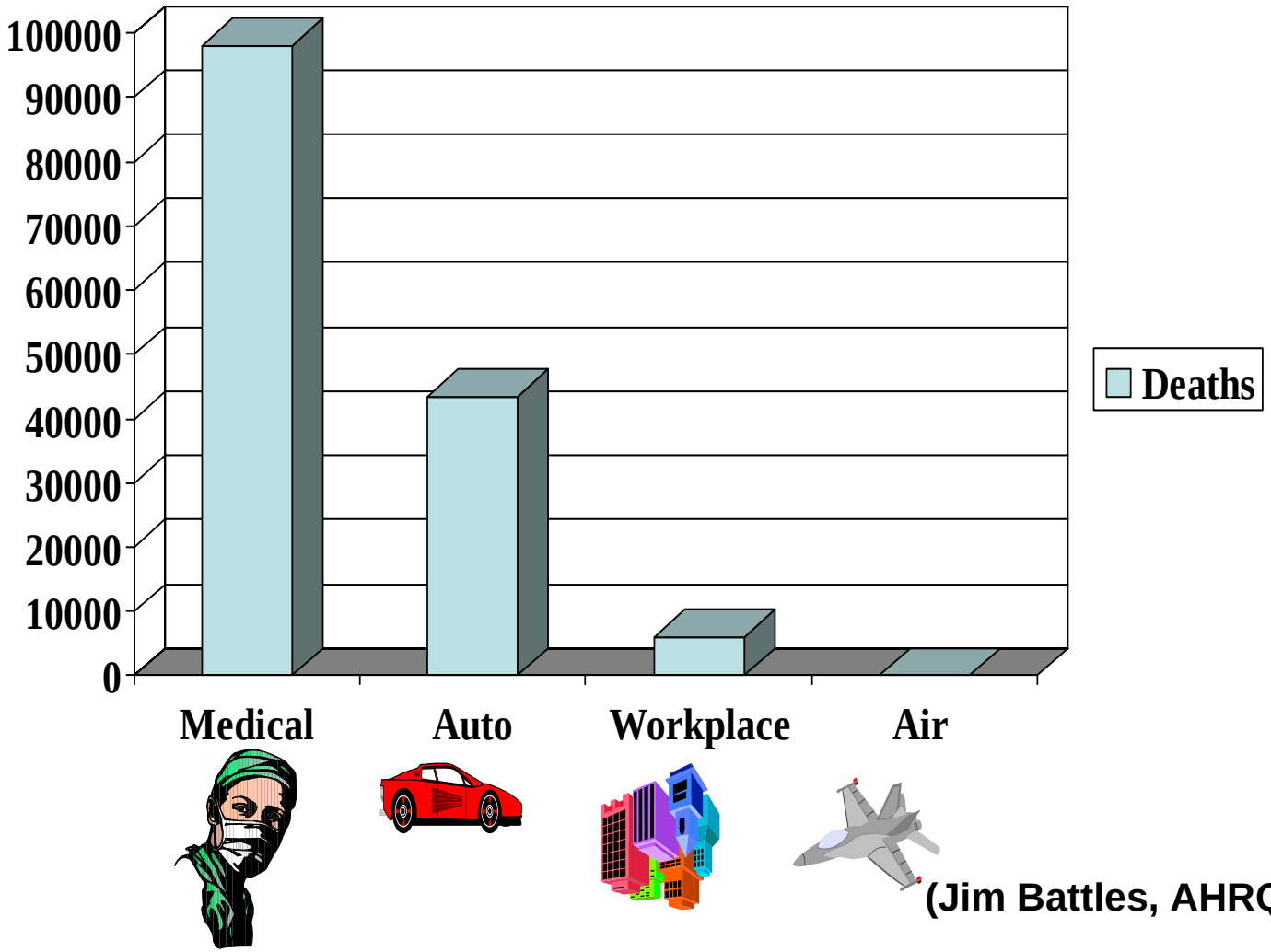
Medical Errors and Patient Safety

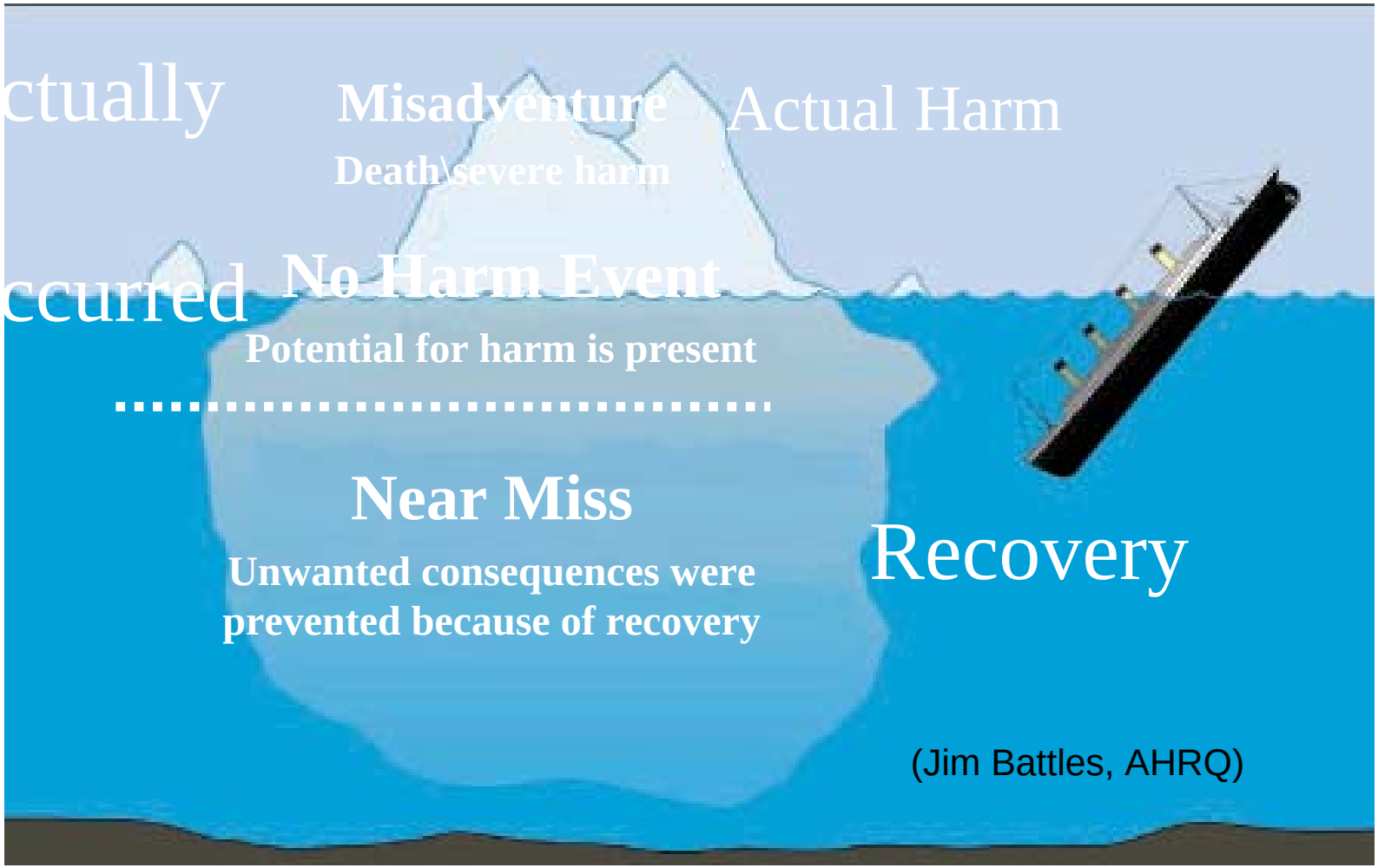
- **Medical errors are a problem of epidemic proportions**
  - **Human and financial costs**
- **Stakeholder response**
  - **Government**
  - **Public/private purchasers**
  - **Providers**
  - **Consumers**

Annual Accidental Deaths



(Jim Battles, AHRQ)

Iceberg Model of Accidents and Errors



Medical Errors are Costly

- $17-29 billion from preventable errors
  - Over 1/2 of costs are direct health care
- Average increased cost of medication error = $4,700 per admission

Systems Problems

- **Errors occur because of systems problems**
  - **Shift focus from blaming individuals to safety improvement**
- **Preventing errors means designing safer systems of care**

IOM Recommendations

- **National focus on safety**
- **Identify and learn from errors**
- **Set performance standards and expectations for safety**
- **Implement safety systems within health care organizations**

Identify and Learn from Errors: Reporting Systems

- **Mandatory**
  - **In all states**
  - **Smaller number of serious events**
  - **Hold institutions accountable**
- **Voluntary**
  - **Promote existing systems**
  - **Larger number of near misses**
  - **Identify system weaknesses**

State Mandatory Reporting Systems

- **22 States report mandatory programs in 2004 (including ME)**
- **Accountability**
  - **Identification of system weaknesses and assurance of corrective actions**
- **Facility education**
  - **Patient safety alerts**
  - **Identification of trends and best practices**
  - **Web-based facility comparisons**

Expectations for Safety: Purchasers

- **Extrapolating costs**
  - **MN: Roughly $1.1 billion spent per year on poor quality care for state employees and public programs; over 5 preventable deaths per week**
- **Educating and informing enrollees**
  - **MA: http://www.state.ma.us/gic/safety.htm**
- **Joining private purchasers**
  - **The Leapfrog Group**
- **Rewarding superior value**

Expectations for Safety: 2003 State Legislative Action

- Facility regulatory requirements (FL, KS, PA)
  - Patient safety officers, committees, plans
  - Disclosure to patients
- Patient safety commissions (MO, NH)
- Patient safety centers (FL, MA, MD, NY, OR, PA)
- Public reports - quality and cost information (FL, IL, PA)

Expectations for Safety: State Legislative Action (con't)

- Statewide electronic infrastructure (FL, IL, WI)
- Peer review protections (FL, MD, WA)
- License fees (OR, WA)
- Prescriptions (FL)
- Nurse ratios (RI)
- Professional licensure requirements (NY)

NQF Safe Practices for Better Healthcare

- Creating a culture of safety
- Matching health care needs with service delivery capability
- Facilitating information transfer and clear communication
- Adopting safe practices for specific settings or processes of care
- Increasing safe medication use

Create Safety Cultures

- Improving patient safety is mostly a cultural change, not a technical change
- Provide leadership
- Create learning environments
  - Internal reporting, root cause analysis
- Job design: simplification and standardization; avoid reliance on memory
- Design for recovery

Facilitate Information Transfer and Safe Medication Use

- Computerized medication order entry can prevent about 84% of dose, frequency, and route errors
- DHHS national health information technology office to promote a national electronic medical records system in 10 years

Information Technology Case Study

- CA 2000 State legislation
  - Info tech to reduce medication errors
  - Facility-wide, multi-disciplinary
- Plans exceed minimum requirements
- Non-technology solutions
- Proactive methodologies help identify and prevent medication errors
- Room for improvement

California HealthCare Foundation, Legislating Medication Safety: The California Experience, http://www.chcf.org/topics/view.cfm?itemid=21576

www.nashp.org

- **State Reporting of Medical Errors and Adverse Events: Results of a 50-State Survey**
- **How States are Responding to Medical Errors: An analysis of Recent State Legislative Proposals**
- **Improving Patient Safety: What States Can Do about Medical Errors**
- **Current State Programs Addressing Medical Errors: An Analysis of Mandatory Reporting and Other Initiatives**
- **Patient Safety and Medical Errors: A Road Map for State Action**

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- **Mandatory Reporting: Legal and Policy Issues**
- **Cost Implications of Administering Mandatory Reporting Programs: A Briefing Paper**
- **How Safe Is Your Health Care? A Workbook for States Seeking to Build Accountability and Quality Improvement Through Mandatory Reporting Systems**
- **State Responses to the Problem of Medical Errors: An Analysis of Recent State Legislative Proposals**
- **Statewide Patient Safety Coalitions: A Status Report**
- Defining Reportable Adverse Events: A Guide for States Tracking Medical Errors
- How States Report Medical Errors to the Public: Issues and Barriers